

AUTHOR'S RESPONSE

Author's Response:

In reply to the letter concerning my article, "Combining Myoma Coagulation with Endometrial Ablation/Resection Reduce Subsequent Surgery Rates," the comments made by Dr Molnar try to compare his series with my series. We are treating different types of patients.

The cases that we performed included myomas that were initially up to 8-10 cm in size. These patients received GnRH analog, which resulted in significant size reduction, then underwent a combination of operative hysteroscopy with resection of submucous myoma and endometrial ablation. Myolysis was performed on the fibroids that were significant in size, were subserosal or through and through transmural and easily identified laparoscopically. Incomplete fibroid removal of a significant size tumor would not inhibit growth. In Dr Molnar's series, the patients underwent hysteroscopic surgery for primary intrauterine myomas and submucosal myomas. The vast majority of his cases included myomas that were less than 3 cm. It is also interesting to note that Dr Molnar's series included 11 cases of patients with endometrial hyperplasia. The main thrust of his surgery was to enucleate the myoma. While this is an excellent approach for the treatment of intrauterine myomas, the cases that we performed were far more advanced. Some of these cases were submucosal, but the vast majority were through and through myomas that were symptomatic for discomfort, pain and pressure as well as uterine bleeding.

Our results showed that when combining myoma coagulation with endometrial ablation/resection in these advanced myoma cases, we can reduce the hysterectomy rates to 5.6%. Approximately 12% of the cases that had significant submucosal myomas required further hysteroscopic therapy to resect tumor(s) that continued to migrate into the uterine cavity. This must be an accepted sequellae rather than a complication. Even if the blood supply is completely destroyed, the fibroid may continue to migrate into the uterine cavity. No follow-up hysteroscopic surgeries were done in Dr Molnar's series. Abdominal hysterectomy was performed. Follow-up hysteroscopic surgery in our series was usually of a minor variety done as an outpatient and not requiring abdominal intervention. As was mentioned, only 5.6% of the patients had signifi-

cant fibroid growth requiring hysterectomy. According to Dr Molnar's criteria, most, if not all our patients would have had abdominal surgery.

Sincerely,

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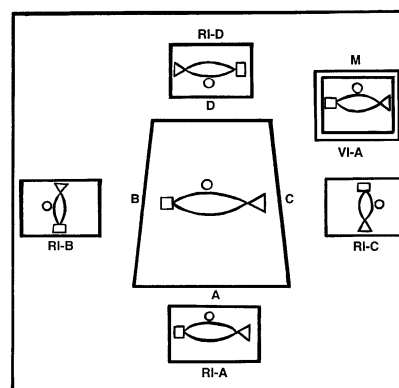
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1. Stringel G, Berezin SH, Bostwick HE, Halata MS. Laparoscopy in the management of children with chronic recurrent abdominal pain. *JLS*. 1999;3:215-219.
2. Stylianos S, Stein JE, Flanigan LM, Hechtman DH. Laparoscopy for diagnosis and treatment of recurrent abdominal pain in children. *J Pediatr Surg*. 1996;31:1158-1160.
3. Schisgall RM. Appendiceal colic in childhood: the role of inspissated casts of stool within the appendix. *Ann Surg*. 1980;192:687-693.

Errata

The following figure has been submitted by the author to correct Figure 2 as published in the following article: Medina M. Image rotation and reversal – major obstacles in learning intracorporeal suturing and knot-tying. *J Soc Laparoendosc Surg*. 1997;1:331-336.



The title was incorrect for Abstract 107 found in *JLS* Vol 4 No 4. The correct title is *Complications of Laparoscopic Procedures after Concentrated Training in Urologic Laparoscopy*.